Filing at a Glance

Company:	Metropolitan Life Insurance Company
Product Name:	Group Life & Accident & Health Insurance Supplement Form
State:	Arkansas
TOI:	L08 Life - Other
Sub-TOI:	L08.000 Life - Other
Filing Type:	Form
Date Submitted:	10/30/2012
SERFF Tr Num:	META-128748974
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	B12-37 SB
Implementation Date Requested:	On Approval
Author(s):	Sandra Bennett, Susan Hoffmann, Ruth Rivera, Linda Williams
Reviewer(s):	Linda Bird (primary)
Disposition Date:	11/02/2012
Disposition Status:	Approved-Closed
Implementation Date:	

State Filing Description:

State: *Arkansas* **Filing Company:** *Metropolitan Life Insurance Company*
TOI/Sub-TOI: *L08 Life - Other/L08.000 Life - Other*
Product Name: *Group Life & Accident & Health Insurance Supplement Form*
Project Name/Number: *GEF09-1 HEA-SUPP/B12-37 SB*

General Information

Project Name: GEF09-1 HEA-SUPP
Project Number: B12-37 SB
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type: Employer, Association, Blanket, Trust, Other
Overall Rate Impact:
Deemer Date:
Submitted By: Ruth Rivera

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments: Filing in domicile state of NY occuring concurrently with this filing. (Domiciliary approval is not required.)
Market Type: Group
Group Market Size: Small and Large
Explanation for Other Group Market Type: Labor Union
Filing Status Changed: 11/02/2012
State Status Changed: 11/02/2012
Created By: Susan Hoffmann
Corresponding Filing Tracking Number:

Filing Description:
We enclose for filing a final printed copy of the form described below.

Form GEF09-1 HEA-SUPP is our Supplementary Health Information Form. This form contains supplemental health questions which will be used to gather certain health information during enrollment when necessary to underwrite the risk.

The form described above may be used in conjunction with the GEF02-1 ADM, GEF09-1 HEA, GEF09-1 FW and GEF09-1 DEC forms previously approved by your Department. When used, this form will always be used with GEF09-1 FW (which includes the fraud warnings) and the GEF09-1 DEC (which includes the signature requirement).

This form may be used in conjunction with any eligible group for which group life and/or accident and health insurance is to be provided and under any group policy and certificate forms previously approved by your Department as well as any of our group policy and certificate forms that may be approved in the future.

In addition with this filing we are requesting an extension of use of the submitted form as well as all of the above referenced previously approved forms with Critical Illness insurance as well as any coverage issued by a MetLife subsidiary or affiliate. In such situations, the form will specifically identify and delineate the coverages that are to be provided by MetLife and those that are to be provided by the MetLife subsidiary or affiliate.

We may incorporate some or all of these supplemental health questions into the previously approved GEF09-1 HEA form.

Formatting Conventions
Variable material is indicated by brackets.

The use of sections and subsections may be added or may vary. Section title, page and section references and question numbers are illustrative. The font size and style but in no event will the text appear in less than 10 point type.

If we remove or add bulleted, numbered or lettered variable items, formatting and grammar will be adjusted accordingly.

The form may be produced to appear in a different format.

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The formatting of the medical questions may change and the questions may appear in any order or combination, may be asked of one or more individuals or any of the questions may be omitted. In those questions that reflect multiple medical conditions, some medical conditions may also be omitted.

Look back periods of 1-10 years may be added to questions 8 and 9.

Bracketed references to a single individual may be revised to reference multiple individuals if coverage is requested for more than one individual. In such a situation, appropriate formatting changes will be made throughout the forms.

References to periods of time or dollar amounts mandated by state or federal laws will vary to conform to changes in such laws.

Contact information for administration offices, such as unit names, addresses and telephone numbers, may vary to accommodate the Employer's plan and their and MetLife's administrative system needs.

The enclosed form may be translated into a language other than English. Any such translation will be performed by a professional translation service, and we will obtain certification from such service that the form, as translated, is an accurate representation of the English language version. The non-English version of the form will include a disclosure in the foreign language indicating that the non-English version is a translation of an English language form, and that in any conflict that may arise between the English and translated version, the English language version of the form will control.

If you have any questions or comments please feel free to contact me.

Company and Contact

Filing Contact Information

Susan Hoffmann, Senior Consultant
13045 Tesson Ferry Road
St. Louis, MO 63128

shoffmann@metlife.com
314-543-1602 [Phone]

Filing Company Information

Metropolitan Life Insurance Company
MetLife
1095 Avenue of the Americas
New York, NY 10036-6796
(212) 578-2211 ext. [Phone]

CoCode: 65978
Group Code: 241
Group Name:
FEIN Number: 13-5581829

State of Domicile: New York
Company Type: Life
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	1 form x $50.00 = $50.00
Per Company:	No

SERFF Tracking #: *META-128748974* ***State Tracking #:*** ***Company Tracking #:*** *B12-37 SB*

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Company	Amount	Date Processed	Transaction #
Metropolitan Life Insurance Company	$50.00	10/30/2012	64404373

SERFF Tracking #:	*META-128748974*	***State Tracking #:***		***Company Tracking #:***	*B12-37 SB*

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	11/02/2012	11/02/2012

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Disposition

Disposition Date: 11/02/2012
Implementation Date:
Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Form	Health Information		Yes

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Form Schedule

Lead Form Number: GEF09-1 HEA-SUPP

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Health Information	GEF09-1 HEA-SUPP	AEF	Initial		56.000	GEF09-1 HEA-SUPP.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

[MetLife
Metropolitan Life Insurance Company, New York, NY]

[HEALTH] INFORMATION

[Please complete all questions below. Omitted information will cause delays. In this section, "you" and "your" refers to the person for whom insurance is being requested.]

[Your name John Doe _____ Employee's Social Security/Identification # 123-45-6789

	Yes	No
1. In the past [1-10 years], have you been Hospitalized as defined below (not including well-baby delivery)? Hospitalized means admission for inpatient care in a hospital; receipt of care in a hospice facility, intermediate care facility, or long term care facility; or receipt of the following treatment wherever performed: chemotherapy, radiation therapy, or dialysis.	☐	☐
2. In the past [1-10 years], have you been diagnosed, treated or given medical advice by a physician or other health care provider for a medical condition or had a surgical procedure (other than oral surgery)?	☐	☐
3. Do you have a biological parent, brother or sister who [,prior to age 55-70,] had been diagnosed, treated or given medical advice by a physician or other health care provider for cardiac or cardiovascular disorder; stroke or circulatory disorder; high blood pressure; cancer, Hodgkin's disease, lymphoma or tumors; diabetes; epilepsy, paralysis, seizures, dizziness or other neurological disorder; kidney disorder; or mental, anxiety, depression, attempted suicide or nervous disorder?	☐	☐
4. In the past [1-5 years], have you been convicted of driving while intoxicated or under the influence of alcohol and/or any drug [or been convicted of [2] or more moving violations] or had a driver's license suspended or revoked? [If "yes", provide State ____and Driver's License # _____]	☐	☐
5. In the past [1-10 years], have you been convicted of a felony?	☐	☐
6. [Except as required as part of your job responsibilities,] in the past [1-5 years], have you participated in [or do you plan to participate in] [hazardous activities such as: scuba diving; bungee jumping; skydiving; hang gliding; parachuting; ballooning; cave exploration; mountain climbing; drag racing; driving a car fitted for competitive racing; aerial hunting; aerial skiing; or travel in an aircraft other than as a passenger]? Indicate activity [and frequency] _____	☐	☐
7. In the past [1-5 years], have you used tobacco [or nicotine] in any form? [☐ cigarettes ___ packs per day ☐ cigar or pipe ☐ smokeless tobacco ☐ electronic cigarettes] ☐ other:_____	☐	☐
8. [Have you ever had an organ transplant, been told by a physician or other health care provider that you require an organ transplant or are you now on a list for organ transplant?]	☐	☐
9. [Have you ever been diagnosed, treated, or given medical advice by a physician or other health care provider for Alzheimer's disease, mild cognitive impairment, Lewy body disease, Pick's disease or other form of dementia or pre-dementia?]]	☐	☐
10. [Have you been advised by a physician or other health care provider that due to an [injury] or sickness, you are expected to die within the next [6-24] months?]	☐	☐]

[For "yes" answers, please provide full details in Section 2, then complete Section 3. If all questions are answered "no," you may proceed directly to Section 3.]

[SECTION 2 – If you need more space to provide full details, attach a separate sheet with the information and sign and date it. Delays in processing your application may occur if complete details are not provided. MetLife may contact you for additional or missing information.
Please provide full details below for each "Yes" answer to questions 1- 3.]

[Question Number	Condition/Diagnosis	Medication Prescribed
		☐ Yes _____ ☐ No
Date of Diagnosis (MM/YYYY)	Date of Last Treatment (MM/YYYY)	Type of Treatment

Treating Health Professional

Personal Physician's Name: _____

Date of last visit: _____ Reason for visit: _____

Address _____

Street City State Zip Code

Telephone: (___) ___ - _____]

GEF09-1
HEA-SUPP

[Question Number	Condition/Diagnosis	Medication Prescribed
		☐ Yes _____ ☐ No
Date of Diagnosis (MM/YYYY)	Date of Last Treatment (MM/YYYY)	Type of Treatment

Treating Health Professional

Personal Physician's Name: _____

Date of last visit: _____ Reason for visit: _____

Address _____

Street City State Zip Code

Telephone: (___) ___-_____]

[Question Number	Condition/Diagnosis	Medication Prescribed
		☐ Yes _____ ☐ No
Date of Diagnosis (MM/YYYY)	Date of Last Treatment (MM/YYYY)	Type of Treatment

Treating Health Professional

Personal Physician's Name: _____

Date of last visit: _____ Reason for visit: _____

Address _____

Street City State Zip Code

Telephone: (___) ___-_____]

[Please provide full details below for each "Yes" answer to questions 4 and 5.]

[Question Number	Date of Conviction (MM/DD/YYYY)	Crime or Offense for which you were convicted
		]

[SECTION 3

1. Personal Physician's Name: _____ Telephone: (___) ___–_____

   Address (Street, City, State, Zip Code): _____

   Date of last visit (MM/DD/YYYY): _____ Reason for visit: _____

2. In the past [1-5 years], have you taken any prescribed medications? ☐ Yes ☐ No

   Medication: _____ Condition/Diagnosis: _____

   Prescribing Physician's Name: _____ Telephone: (___) ___–_____

   Address (Street, City, State, Zip Code): ___]_____

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Supporting Document Schedules

		Item Status:	**Status Date:**
Satisfied - Item:	Flesch Certification		
Comments:	Attached are certifications regarding readability and Rule & Reg 19. Since this is an application type filing, Rule & Reg 49 as well as the Consumer Information Notice are not applicable.		
Attachment(s):			
AR Rule & Reg 19 Certification.pdf AR Readability Certification.pdf			

MetLife®

Metropolitan Life Insurance Company
NAIC Company Number: 65978
NAIC Group Number: 241

ARKANSAS CERTIFICATION
Rule and Regulation 19
Unfair Sex Discrimination in the Sale of Insurance

I certify that this submission meets the provisions of Rule and Regulation 19, and all applicable requirements of the Arkansas Department of Insurance.

Howard Koransky
Vice President

ARCERTREG19

MetLife®

Metropolitan Life Insurance Company
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ARKANSAS FLESCH CERTIFICATION

I certify that the form shown below has achieved the Flesch Reading Ease Score shown below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form No.	Form Description	Flesch Score
GEF09-1 HEA-SUPP	Enrollment Form	56.0

Howard Koransky
Vice President

ARCERTREAD